*International Journal of Short-Term Psychotherapy, Vol. 8, 3-22(1993)*

# *A* Comparison of Seven Approaches to Brief Psychotherapy

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Despite the growing literature on short-term dynamic psychotherapy, there are, to date, no review articles which examine more than three or four of the prominent methods currently in use. In this article, seven of the major, current approaches to short-term psychotherapy will be examined. For each one, the basic selection, criteria, technique, and outcome will be summarized, permitting the reader to become acquainted with their respective distinguishing characteristics. The schools which will be reviewed are those of: Davanloo, Sifneos, Malan, Luborsky, Mann, Strupp and Klerman. This is by no means a complete review of the literature on brief dynamic psychotherapy, but simply a beginning, as many other practitioners had to be omitted due to constraints of space. The authors felt that, due to the very rapid growth of this field, that an attempt to clarify the major techniques currently in use was necessary.

## History

Although short-term dynamic therapy is very much on the forefront of current innovations in practice, it actually has its roots within the early history of the psychoanalytic movement. Freud himself conducted quite a number of treatments in a very short period of time (anywhere from six sessions to 6 months) (Bauer and Kobos, 1984). Immediately following Freud, and shortly after his analysis with Freud, Ferenczi started to develop his technique of active therapy (1920), where he became less passive and more active with patients, in part, by setting a time limit on the treatment. In addition, he prohibited certain behaviors, such as the performance of rituals by obsessive patients, and he encouraged other behaviors which may have been avoided.

Otto Rank, a contemporary of Ferenczi's, was also experimenting (1924) with short-term treatment. He was the first to use time limits to specifically address his patient's separation problems. The ideas of Ferenczi and Rank were, however,

0884-724X /93/010003-20$15.00 

strongly opposed in analytic circles of the time and were seen as a threat to certain of Freud's ideas. These reactions eventually led to a halt in the development of short-term dynamic therapy until some time after World War II (Bauer and Kobos, 1984). Franz Alexander at the Chicago Institute for Psychoanalysis was the next person to experiment with short-term methods (1946). Alexander and French (1946) adjusted the treatment length to ht the patient's needs. Alexander emphasized that the therapist could he more active if need be, and need not be a blank screen. His therapy (Bauer and Kobos, 1984) focused on current life problems; minimized regression; and emphasized reality, problem solving, and new learning. Unfortunately, Bauer and Kobos (1984) report, Alexander's contemporaries criticized him for abandoning psychoanalytic principles. Currently, however, his principles are widely used by many therapies, particularly short-term psychoanalytic psychotherapy.

There are certain elements common to all the disparate approaches to short-term dynamic therapy. Although the techniques have their base in psychodyna-mic theory, there are a number of modifications from traditional psychoanalysis. One change is that most of the methods have very strict criteria for who they accept as patients. More recently, though Sifneos reports (1984b) that efforts to include more disturbed patients are being made if they fulfill at least two criteria: an ability to work within the treatment; and a real motivation to change. The second change is the use of a specific focus which both therapist and patient agree to adhere to as much as possible. Sifneos (1984a) reports that those types of difficulties which respond best to these short, focused treatments are agreed to be; grief reactions, separation and loss issues, and unresolved Oedipal issues. A third variation is the use of a preset termination date, or a limited number of sessions. Short-term therapy should be no longer than 1 year (Sifneos, 1984b), but most run less than 6 months. Sifneos reports (1984b) for example, that Malan's therapy usually runs anywhere from 30 to 40 sessions, while Mann's treatment technique is exactly 12 sessions. Finally, one of the most striking innovations of short-term dynamic therapy is the taking of a very active stance on the part of the therapist. The therapist makes very challenging confrontations, and offers frequent interpretations, both of which are used very sparingly in traditional, long-term psychodynamic psychotherapy.

## Schools of Short-Term Dynamic Therapy

### *Davanloo's Intensive Short-Term Dynamic Psychotherapy*

Davanloo initiated his work on Brier Therapy in 1962 from the Montreal General hospital on brief therapy in 1962. He termed his technique Short-Term Dynamic Psychotherapy or S-TDP (1980, 1978). More recently, Davanloo (1987) refers to his method as Intensive Short-Term Psychotherapy (IS-TDP). For a more in-depth review description of the therapeutic process, the reader is referred to Davanloo (1978, 1980,1990).

**Selection**. Davanloo conducts a very detailed evaluation interview, in which trial interpretations are made in order to see how the patient responds and to judge from this if the patient is appropriate for this type of treatment. The

evaluation occupies a central place in Davanloo's treatment, and may take up to 3 hours total in separate interviews. The patient must have the following characteristics:

(1) *Psychological Mindedness.* The patient must have the capacity for introspection and be able to report their thoughts and feelings.
(2) *Intelligence.* It is important for the patient to be of above average intelligence.
(3) *Response to Interpretation,* This is one of the most important aspects, because with this, Davanloo is able to see how the patient actually responds to his technique.
(4) *Quality of Relations.* This is seen in the type of relation the patient forms with the evaluator.
(5) *Handling of Affect.* Davanloo provokes a considerable amount of affect in therapy, so the patient needs the ability to tolerate strong affect and not develop symptoms as a result.
(6) *Defensive Organization.* The defenses must be flexible, and must not be solely primitive in nature (e.g., projection, acting-out, or denial).

Despite these desirable qualities for the traditional Davanloo technique, in recent years Davanloo has sufficiently modified his technique to make it accessible not only to more highly resistant depressed and characterological patients, but also to patients with more functional disorders such as the various psychosomatic disorders (Davanloo, 1987). He currently (1988) views as contraindications to IS-TDP, the following; sociopathy, borderline personality disorder, alcoholism or drug abuse, psychosis, bipolar illness, or very fragile ego structure.

**Technique**. Davanloo's technique is close to classical analysis with its focus on interpretation of "drive-defense constellations" (Rasmussen and Messer, 1986). The patient is given a full psychodynamic formulation of the problem, linking the transference, present relationships, and past figures. Freud presented the technique of free association for discovering the patient's resistances and moving beyond them to the unconscious thoughts and feelings. Davanloo, in order to hasten the process of traditional psychoanalysis has developed a very active technique, which applies pressure on the ego, to lead to a revealing of the unconscious. There is no present time limit, but an estimate is given. Davanloo has found that the therapy may take 5-10 sessions if the focus is oedipal and the patient is very motivated. The treatment might extend to 5-15 sessions if the patient is motivated, but the issue is loss. Patients with more severe problems, including the more serious obsessive/compulsive and phobic symptoms, are seen from 15 to 40 sessions. Approximately 33% of those seeking treatment with Davanloo are seen this long. The focal issue is shared with and agreed upon with the patient. The therapist in STDP is neutral, and does not give advice. Davanloo works with the patient at a very high level of emotional intensity. He introduces the patient into IS-TDP with confrontations which are intended to elicit the underlying thoughts and feelings.

(1) *Opening Phase.* In the opening phase {the first five sessions), the concentration is on feelings about the therapist, or transference feelings. The technique involves, at this point, constant questioning of the patient to find out what the patient feels in the moment. Subtle signs of resistance are brought to the patient's attention immediately, such as eye movement,

changes in posture, etc. As the patient's defenses are mobilized in response to this confrontation, the defenses themselves are challenged, until the patient is able to express anger directly and without reservations. This process is repeated over and over again, until the resistance decreases and the material emerges in the midphase of treatment.

(2) *Midphase.* The midphase of treatment involves less focus on transference and more emphasis on the patient's material. There is frequent repetition of interpretations until the patient acknowledges them.

(3) *End.* The end of treatment occurs when there is a cessation of the initial symptoms. Termination is brief, and the patient's mastery over the initial problems is reviewed. If the focal conflict involved is loss, termination might be longer (5-6 sessions), instead of one session for oedipal issues.

Although the above categories still broadly outline his method, in recent publications, Davanloo has modified and refined both his initial evaluation sessions (trial therapy), and the entire process, which he now terms "unlocking the unconscious" (1989). With more seriously disturbed patients, more preparatory work must be done to "restructure the ego-syntonic defenses to ego-dysto-nic" (Davanloo, 1988, p. 101) ones before unlocking the unconscious.

Davanloo describes his technique of unlocking the unconscious as consisting of the following phases (Davanloo, 1988, p. 99-100):

*" Phase 1*
- a. Inquiry . . .
- b. Rapid identification and clarification of patient's defenses.

*Phase 2* Pressure, leading to resistance.

*Phase* 3 Clarification of defenses.
- a. Clarification, challenge to defenses, leading to rising transference and increased resistance.
- b. Challenge directed against the defenses. . .
- c. Challenge directed toward the therapeutic alliance.
- d. To make the patient acquainted with his defenses . . .
- e. To turn the patient against his own defenses.

*Phase 4* Transference Resistance.
- a. Clarification and challenge to transference resistance.
- b. Head-on collision with the transference resistance ...
- c. Exhaustion of resistance . . .

*Phase 5* Intrapsychic Crisis.
- a.... breakthrough of the complex transference feeling—the triggering mechanism for unlocking the unconscious.
- b. Interpretive phase.
- c. The first direct view of the multifoci core neurotic structure.

*Phase 6* . . .analysis of the transference ...

*Phase 7* Inquiry, completing .. .history.

*Phase 8* Direct view of the multifoci core neurotic structure and its relation to patient's symptom and character disturbances and psychotherapeutic plan."

This is the basic technique for triggering a "major unlocking of the unconscious" (Davanloo, 1987, p. 100), much of which can be done in one interview. This

trial therapy, with neurotics, leads to a view of the "core neurotic structure" (Davanloo, 1987, p. 100).

With very resistant, depressed and psychosomatic patients, however, an excess of early challenging raises their anxiety level, which leads to an increase in symptoms. Therefore, with this group, the defense mechanisms are first restructured, then more challenge can be applied toward discovering the unconscious. The main technique for working with very resistant clients is as follows (Davanloo, 1987, p. 100):

(1) A push for the unconscious (UCS) feelings, which increases resistance.
(2) A challenge of the resistance, which increases the transference.
(3) A challenge of the transference-resistance.
(4) Confronting the transference-resistance directly.
(5) Transference feelings come to the fore—the "triggering mechanism".
(6) "Mobilization of the UCS therapeutic alliance, and the first unlocking of the UCS."
(7) "Systematic analysis of the transference ..."
(8) Past (C) and distant past (P) conflicts emerge, allowing a view of the UCS and neurotic conflicts.

This technique is used with most resistant patients, including character disorders. However, with patients who have functional disorders, such as migraine and irritable bowel syndrome or chronic depression, this technique has to be modified, since the patient frequently is unable to distinguish between the feelings, of rage, for example, and anxiety. The feelings thus go directly into the symptom. The technique of restructuring is used first in these cases. Initially, with this sort of patient, the therapist is very careful not to arouse an undue amount of anxiety, and the relationship between the transference, current and past feelings is repeatedly analyzed. This phase is referred to as consolidation. Only after this restructuring phase can the therapist proceed to the unlocking of the UCS. After the restructuring phase with these patients, the interview can proceed with further challenge, reduction of pressure, and eventually a release of the impulse and insight. What is unique to this technique as applied to this population is the use of a reduction of pressure, as opposed to the constant use of pressure and challenge for the usual technique. This modification allows therapists using IS-TDP to greatly increase the range of diagnostic categories with which they can successfully work. In addition, this method of challenging the resistance, since it is more powerful than interpretation alone, allows the work to be more broadly focused, rather than having to focus only on one particular issue.

Davanloo's technique, in general, requires fairly consistent neutrality on the part of the therapist, more so than the other short-term techniques described in this paper. Therapists need to be constantly alert to changes occurring with the patient. Because the therapy moves so rapidly, the therapist must make psychodynamic formulations quickly and with ease. Davanloo's interpretations have been generally described as 'penetrating and relentless' (Rasmussen and Messer, 1986).

**Outcome**. From a group of patients treated between 1963 and 1974, 115 were judged to have had a successful treatment. Gains on the 40% of patients followed

up on at 2 to 7 years were found to be maintained (Flegenheimer, 1982). In another large research study, Davanloo (1980) found that 115 out of 130 patients were successfully treated with S-TDP in an average of about 20 sessions.

### *Sifneos' Short-Term Anxiety-Provoking therapy*

Peter E. Sifneos (1972, 1979) is based at the Beth Israel Hospital in Boston, where he developed his technique of Short-Term Anxiety-Provoking Psychotherapy (S-TAPP).

**Selection.** Sifneos uses a set of strict selection criteria:

(1) Ability to have a very limited main complaint, and to stick to it.
(2) Evidence of meaningful past relationships (mature object relations) so the patient will interact well with the therapist, and be capable of emotional involvement.
(3) Flexibility in the interview. This is evidenced by the operation of an observing ego (ability to distance one's self from the immediate material), and
flexibility and range of affect.
(4) Above average intelligence and psychological sophistication.
(5) Motivation for change-real change, and not just symptom relief. There are seven subcategories within this criteria:

(a) Ability to see that symptoms are psychological in nature.
(b) Capacity for introspection, and the capability to give an honest report of emotional problems (this rules out projection and acting-out as primary defenses).
(c) Active participation in the treatment. The patient must be active with the therapist's comments, and be able to argue back with the therapist in the first session.
(d) Curiosity to understand themselves.
(e) Realistic expectations of psychotherapy.
(f) Willingness to make sacrifices for the treatment.

If the patient meets six to seven of the above qualities, they are seen as possessing good motivation; meeting five criteria is rated as fair motivation; four criteria is classed as questionable motivation; and finally, less then four rates a candidate as unmotivated.

Sifneos treats a wide variety of patients, including those with; anxiety attacks, depression, phobias, mild obsessional symptoms, and physical symptoms. In fact, even more common than symptoms are patients with problems in interpersonal relationships. These might involve problems with romantic relationships or authority figures. The duration and severity of symptoms are not necessarily part of the inclusion criteria. Sifneos finds that unresolved oedipal problems, and difficulty with separation and loss usually respond best to this treatment (1984a).

Sifneos has described the use of S-TAPP with patients with physical symptoms whose origin is psychological, and with phobic and mildly obsessive-compulsive patients (1984a, 1985). He has found (1985) that this technique can be used in a modified form with these patients provided that they have good ego strength, and have predominantly positive feelings for both parents. With anxious patients with early separation issues, ambivalence and characterological

passivity, the problems are more serious and require long-term psychotherapy. With phobic patients, the more focused the phobic symptom, the easier it is to treat, while the more diffuse the symptom, the better the patient is suited for long-term treatment.

**Technique**. Before the actual treatment begins, the therapist and patient agree on a psychoanalytic hypothesis of the patient's problems which becomes the focus of the treatment (Sif neos, 1985). In addition, the outcome criteria are written at the end of the first evaluation session. There is no end date or number of sessions proscribed at the onset of treatment. Rather, the patient is given a "flexible but brief time interval" (Sifneos, 1984a, p. 49) as an estimate of the length of treatment. Flegenheimer has reported (1982) that 90% of Sifneos' cases are seen for 12 to 16 sessions, while roughly 10% last 16-20 sessions, and none are seen beyond 20 sessions. Sifneos' method consists of the following basic techniques (1985):

(1) The therapist is very active.
(2) Both parties remain with the focus.
(3) A working alliance is absolutely necessary, that is, a sense of working together.
(4) The mainly positive transference feelings are used very early on in the treatment.
(5) The patient is confronted very early in the process, in an anxiety-provoking fashion.
(6) Interpretations are made which link past and present.
(7) There is frequent use of problem solving with the patient.
(8) There is "recapitulation at times of resistance" (Sifneos, 1985).
(9) Any early preoedipal issues are avoided and are seen as a way of avoiding the anxiety induced by the therapist's interpretations.

The first part of the treatment is to make the patient aware of the central conflict, and then Sifneos and the patient come to an agreement about what the central conflict is, Sifneos' technique is more emotionally intense than is Malan's. Sifneos sees himself as a teacher (Burke, White and Havens, 1979), provoking patients, instructing them about themselves, and showing them new coping mechanisms.

Quite often, the therapist will link the patient's feelings for the therapist with the patient's feelings for important people in the past. When resistance arises, the therapist becomes even more active with interpretations assuming it may be due to transference issues. Sifneos uses a different technique often with interpretation, than other clinicians in the field. Rather than working first on understanding the defenses, he interprets the underlying conflict directly, which increases the patient's anxiety and resistance, hence the name of his technique (Sifneos, 1984b). Sifneos also feels that because free association is not used, and because the treatment is short term, no transference neurosis sets in. He then stops the treatment before any transference neurosis develops (Sifneos, 1984b). He states that many other short-term practitioners disagree with this, and feel that a transference neurosis does arise in many short-term therapies.

Unlike most other short-term practitioners, Sifneos feels detailed note-taking is essential during treatment sessions to capture accurately he wording of

patients. This allows the therapist to be able to repeat and use the patient's phrases in interpretations in subsequent sessions. Often, the therapist takes a direct educational stance, showing the patient how, with the new insights gained in treatment, the patient can use more adaptive ways of handling problems in his or her life. He feels that S-TAPP also uses principles from learning theory and behavior modification, for example, reinforcement and reward to patients for their work. He feels this helps patients internalize their new learning.

In addition, Sifneos has found that S-TAPP progresses fairly smoothly in patients with unresolved oedipal problems, who have mainly positive feelings for both parents. Where negative feelings are more salient, however, the treatment becomes more difficult, and usually longer. Termination occurs when there is behavior change, or more adaptive handling of problems by the patients. This is viewed as sufficient evidence of progress.

**Outcome**. Sifneos, in his 1979 book, reports on his various research studies. He examines efficacy by rating subjects on a number of very specific outcome criteria. Overall, the majority of patients show symptom relief, increased self-esteem, and improved insight and coping abilities. In a 4-year long-term follow-up of 21 patients, percentages of patients improving was found to be as follows: 82% had improved self-esteem; 58% had moderate symptom relief; 91% had increased self-understanding; and 86% had new attitudes and behavior patterns (p. 169).

Sifneos (1984a) reports on two other outcome studies. In the first, 23 patients were followed-up at 1-3 years post-treatment. Seventeen patients were rated as being much better, and six patients were judged to be a little better. These six had issues of loss in addition to unresolved oedipal conflicts, which is a factor Sifneos has described as lengthening the course of treatment. In the second research study, a group of 14 patients who had physical symptoms in addition to psychological problems were studied, with complaints such as: pain, migraine, impotence, insomnia, diarrhoea, anorexia, overeating and skin problems. These patients were part of a larger study of 48 patients investigating the effectiveness of S-TAPP. Thirteen of these subjects were in the experimental group, and received short-term anxiety-provoking therapy, while the one control subject was on a wait-list to receive S-TAPP. Of these 14 subjects with physical symptoms, only one was subsequently rated as unchanged both physically and psychologically. It is not clear which patient this was, although we can assume that this one patient must have been the control subject. In 5 of the remaining 13 patients, the physical symptoms had dissipated, and in 7 others the physical problems were much better. In fact, only in one subject, were the somatic symptoms rated as only slightly better. The author concludes then, that S-TAPP is effective not only for psychological complaints, but for somatic symptoms as well.

### *Malan's Tavistock System of Short-Term Dynamic Psychotherapy*

David Malan worked with Michael Balint at the Tavistock Ciinic in London on instructing psychoanaly tically trained therapists in Brief Psychotherapy (BP)

(Malan, 1963 and 1976), or the Tavistock System of Short-Term Dynamic Psychotherapy and continued his work there after Balint's death. He has altered it over the years, bringing it more in line with Davanloo's technique, and now writes actively in support of Davanloo's technique of restructuring. The revised Malan technique has the following steps:

(1) Through a careful history, patients who are unsuitable for insight-oriented work are selected out.
(2) Trial therapy, with several interpretations, is carried out, while carefully observing the patient's reactions to the interpretations.

**Selection**. The selection criteria are as follows:

{1) No specific diagnostic groups are ruled out.
(2) The interviewer, through the history taking process, makes a detailed psychodynamic formulation.
(3) The patient reacts favorably to the initial interpretations, and exhibits both the capacity and motivation to work with them.

This central theme or interpretation becomes the focus of the entire therapy. Malan views these techniques are being central to most schools of short-term psychotherapy, and so does not differentiate his method because of them.

Technique. The first task of Brief Therapy is to determine a focus for the treatment. The patient's responses to the test interpretations help guide the focus of the treatment. Malan does not share this focus with the patient (Burke *et ah,* 1979). The focus is based on the patient's psychodynamic history, but does not have to be an oedipal conflict. Malan's Brief Psychotherapy allows more sessions than most of the brief therapies (up to 30 or 40 sessions), and permits more dependency on the therapist (Barth, Nielsen, Havick, Haver, Mol-stad, Rogge, Skatun, Heiberg, Ursin, 1988). There is no preset time limit, instead, patients are told the treatment will take a few months.

The impulse-anxiety-defense problem is tackled by interpreting the defenses first, and later, the underlying conflict may or may not be interpreted. Interpretations which link the transference to earlier figures in a patient's life are more often, and are actually seen as one of the most important factors in good outcome. The therapist must stay active in order to keep the patient within the focal area. The interventions are not necessarily extremely confronting, although deep interpretations are made. The technique is very similar to the standard technique for long-term psychodynamic psychotherapy, although it is more focused. The main technique is using anxiety-provoking confrontations. The therapist does this by directly confronting such patient defenses as straying away from the focus, lateness, or disagreements with the therapist. Malan's approach is more distanced and didactic than that of either Davanloo or Sifneos (Burke *et al.* 1979); he is less intense and "remains removed from the patient, somewhat shadowy and uninvolved" (p.178). Basically, after the defenses have been exposed and

discussed, the treatment ends with a downplaying of the termination issue. Insight is viewed as the curative factor.

**Outcome**. Malan has published two studies of his Brief Psychotherapy (1963, 1976). His first (1963) study looked at the case histories of patients seen by both he and his co-workers. Successful outcome was found to be related to certain conditions within the treatment, particularly using transference-parent link interpretations. In his 1976 study, Malan found (cited by Bauer & Kobos, 1984) that positive outcome was very related to the delineation of the focus and the patient's ability to work with this focus. The transference-parent link was again found to be very important. Outcome was studied via summaries of sessions, not verbatim accounts, however, and the findings were mainly gleaned from correlational statistics, which do not infer causation.

There is, however, a group of psychiatrists in Oslo who have constructed an outcome scale based on follow-up forms of both Sifneos (1972) and Malan (1958). The form (Husby, Dahl, Dahl, Heiberg, Olafsen & Weisoeth, 1985a) evaluates different measures of outcome, such as, change in social functioning, symptom relief and increased insight into presenting problem. The reliability coefficients (the consistency with which a test measures a certain trait) for the scale varied from 0.56 to 0.7, depending on the specific outcome variable. The Oslo group (Husby, Dahl, Dahl, Heiberg, Olafsen & Weisoeth, 1985b) then studied 39 patients, evaluated for either Sifneos' Short-Term Anxiety-Provoking Psychotherapy, or Malan's Brief Psychotherapy, and treated them according to one of these two techniques. A total of 36 patients were seen at a 2-year follow-up period, and interviewed by three evaluators. There were many patients (67%) with high scores on symptom relief and social functioning, but few with high scores on internal changes in insight (31%). A 5-year follow-up study by Husby (1985) reported that gains were maintained at a 5-year follow-up assessment. A 1988 study by Barth, Nielsen, Havik, Haver, Molstad, Rogge, Skatun, HeibergandUrsin, also in Oslo, discovered that 86% of patients treated according to Brief Psychotherapy principles showed "substantial symptom relief" (p. 157), with 41% getting a high score on change in insight. There was a maintenance of positive changes for most patients at a 2-year follow-up.

More recently, Malan has become somewhat disillusioned with the limitations of his technique, and in 1986, reported that with a follow-up period of up to 8 years, there have been some patients (the numbers are not reported), who are able to resolve their central problem completely. Many of the remaining patients, Malan states, actually do achieve permanent and deep personality changes. However, on a more pessimistic note, Malan describes that of all the patients referred to his group for this treatment, only perhaps 3% pass the selection criteria, and of this few percent, only 25% achieve 'major therapeutic results' (p. 62). Malan concludes by speculating that interpretation alone can only reach a very small minority of patients, and that something more than interpretation is needed in most cases. He actually states, in an interview (Trujillo, Nahmias, Said, Worchel, Zois, 1986, p. 33), that "The Tavistock system of short-term psychotherapy has limited effectiveness because it is based entirely on interpretation."

Malan's view (1986) is that Davanloo's technique of challenge to the resistance

is a means of reaching a larger group of patients than was previously accessible to most short-term dynamic therapies. He believes (Malan, 1986} that Davanloo's technique is able to reach a much wider group of patients and with more success than his own.

### *Luborsky's Time-Limited Dynamic Supportive-Expressive Psychotherapy*

Lester Luborsky, working at the University of Pennsylvania, developed the method of "time-limited, manual-guided, dynamic supportive-expressive (SE) psychotherapy" (p. 110). His book describing the technique (Luborsky, 1984) provides much more detailed information about the general technique of SE psychotherapy in its original, open-ended form (unlimited time period). His recent chapter written with Mark (1991), focuses solely on the short-term model of SE psychotherapy. The method is based on the standard classical technique of psychodynamic psychotherapy, as first described by Freud. The term suppor tive describes those techniques which attempt to keep the patient at a certain stable functioning level, while expressive refers to those techniques which attempt to explore the patient's difficulties and promote insight. Special versions of SE (time-limited) have been developed for work with drug-dependence {24 session limit), and depression (16 session limit).

**Selection.** Luborsky and Mark (1991) report that time-limited SE treatment is useful with a large group of patients, for if a patient is at a lower functioning level, the therapist can use more supportive, rather than more expressive techniques. There are some exceptions to this, however: patients with suicidal impulses who have difficulty with dependency needs and separation; borderline personality and psychotic patients; patients with antisocial personality; and patients with personality disorders who may need longer-term treatment, especially those who also have an Axis I diagnosis.

**Technique.** Time-limited SE treatment usually lasts from 16 to 25 sessions. The goals for the therapy are set in the initial sessions, and are formulated with the patient's help, the goals concern the problems which the patient wants to work on. In addition, the goal may be seen in terms of what the therapist sees as the patient's core Conflictual Relationship Theme (CCRT). The CCRT has to do with the patient's main relationship pattern in the past, and how? this gets the patient into trouble in his/her relationships in the present. The CCRT is "a general relationship pattern that recurrently becomes activated throughout the therapy and perhaps throughout life." (Luborsky and Mark, 1991, p.119). The CCRT is very similar to Freud's description of transference, but the CCRT is operationally defined so that it facilitates inter-rater agreement. In making the CCRT formulation, the therapist listens for three areas of a patient's story: "the patient's wishes from the other person, the other person's actual or expected responses, and how the patient responds" (Luborsky and Mark, 1991, p. 119).

The central techniques of time-limited SE treatment, as delineated by Luborsky and Mark (1991), in order of relative importance, are:

(1) "Be sensitive to allowing the patient to form a helping alliance" (p. 120).
(2) "Formulate and respond about the central relationship patterns" (p.121).
(3) "Attend and respond to each sphere of the relationship triad, including the one with the therapist" (p. 122). This includes helping the patients see patterns in three areas of relationships: the relationship with the thera pist, past relationships, and current relationships outside the treatment.
(4) "Understand and respond where the symptom fits into the pattern" (p. 124).
(5) "Attend to and respond to concerns about getting involved in the therapy and then separating" (p. 124). The therapist should occasionally remind the patient of the length of treatment. There is also a processing of the meaning of termination with the patient, which is fairly unusual in most of the short-term therapies. The patient is consulted as to what kind of contact they would like, if any, once the treatment is ended, for example, a follow-up session(s), telephone call or letter to inform the therapist of the patient's progress.
(6) "Responses should be timed in relation to the patient's awareness" (p. 125). This technique, also, is very different from the style of Davanloo, and Sifneos, in particular.
(7) "Recognize the patient's need to test the relationship in transference terms" (p.126).
(8) "Frame the symptoms as problem-solving or coping attempts" (p. 126). This helps the patients take a more benign view of their symptoms, and to be less self-critical.
(9) "Reflect on your usual types of countertransference responses" (p. 127). It is very unusual for countertransference to be mentioned in the short-term dynamic therapies. Luborsky writes that an awareness of the reactions patients set up in their therapists helps the therapists not to respond in a negative fashion, but in a manner to help the patient.
(10) "Interventions should be timed to suit the length of a session" (p. 128).
(11) "Interventions should be limited in complexity and length" (p. 128). This style is very different from the educative approaches of Sifneos and Malan, Luborsky states that the patient learns best when the therapist makes shorter interventions which are easier to assimilate.
(12) "The patient's shifts in mental state can be an opportunity for responses" (p. 128).
(13) "The match of patient's with therapist's messages is a measure of the ade quacy of the therapist's responses" (p. 129). Luborsky has found (Luborsky and Mark, 1991) that this last technique correlates with positive therapeutic outcome.

**Outcome**. Time-limited SE treatment has been shown to be (Luborsky & Mark, 1991) as effective as cognitive-behavioral therapy in treating heroin addicts and cocaine addicts, and additional studies on depressed patients and personality disorders are currently under way. The results of research on the success of the openended form of SE treatment are quite positive, though, showing a majority of patients receiving major benefits from the treatment. The majority of Luborsky's techniques are based on his extensive research in the area of short-term psychotherapy, in terms of what has been found to be effective, making it an empirically based technique.

### *Mann's Time-Limited Psychotherapy*

James Mann, working at the Boston University School of Medicine, developed his own technique, which is termed Time-limited Psychotherapy, or T-LP

(Mann, 1973). His technique is closer in style to that of Object Relations Theory, and Self Psychology, than that of classical analysis, in the way he looks at separ-ation-individuation issues, preoedipal problems, and the therapist-patient relationship {Rasmussen and Messer, 1986). Mann works in a somewhat existential way, helping the patient develop his self-esteem and reliance on himself, partly through the preset time limit. Unlike Malan, Sifneos,and Davanloo who stress intrapsychic conflict, Mann believes the patient's problems have to do with the universal problems of passivity, dependence and self-esteem which stem from a period of life when the child needs to separate from the mother (Burke *et al.* 1979). He then goes about recapitulating this period of life within the time constraints of the treatment situation.

**Selection**. Mann (1991) states that a wider variety of patients can be treated with this model than was at first thought. There are, however, two important selection criteria to assess for in the early evaluation session. The first is a sufficient degree of ego strength to tolerate this therapeutic technique. The second requirement—which is actually a subset of ego strength—is what Mann calls (1991, p. 19), the "capacity for ... rapid affective involvement and equally rapid disengagement—a measure of the capacity to tolerate loss." The therapist assesses the ability to tolerate loss in the evaluation sessions, when the patient's manner of handling past losses is appraised. Mann would include within this group amenable to T-LP, both oedipal and preoedipal disorders. Categories of patients he would exclude, due to the need for more long-term treatment are patients with: obsessive-compulsive disorder who use mainly intellectualization and isolation as defenses; schizophrenia; bipolar affective disorder; schizoid personality; and the more severe borderline personality disorders.

**Technique**. Mann limits the treatment to exactly 12 sessions. The focus is on the main issue that addresses the patient's self-esteem and underlying conflict, this is state in simple terms which the patient's ego can easily receive. He views empathy as being central, just as Kohut does, and sees the time element in his therapy as paralleling development in its stages of separation-individuation. Mann's central focus is more about present day problems than intrapsychic conflict, which, as was mentioned earlier, is different from most of the techniques discussed above (Rasmussen and Messer, 1986). Mann's focus speaks to the patient's "felt pain" (Burke *et al* 1979). The focus is agreed upon with the patient, and it has an empathic purpose, that is, to convey understanding to the patient. His style is more gentle than Davanloo's, and Mann does not stick as closely to the central conflict.

Mann uses techniques such as mirroring the patient by repeating the patient's words. This helps to create a bond between patient and therapist. He treats the patient's defenses very carefully, which again, is very different from some of the other short-term approaches discussed above. He is very understanding of the patient's defenses and the function they serve, while subtly helping the patient gain psychological connections between past and present. In the fifth session, he begins to separate himself from the patient by forcing the patient to look at his/her tendencies to depend on the therapist. At this point, he confronts the patient on needing to please him, and encourages the patient to be

true to his/herself and his/her own needs. With this, the patient becomes aware of his/her own separateness from others and feels the loss associated with this stage. Towards the end of treatment, he confronts the ambivalence about termination. Mann considers the termination stage as a crucial part of the treatment in terms of aiding the patient with separation. The issues of sadness, grief and anger must be actively explored at this stage. Rasmussen and Messer (1986) sum up the Mann style as follows, his "... method is more incorporative, soothing and affirming, framing his interpretation in assuaging universal and preoe-dipal terms that soften the narcissistic injury inherent in interpretation." (p. 181). His style is very gentle, in fact, more like that of a mother for her child. Mann uses less education than Sifneos, Davanloo and Malan, and more exploration. For Mann, the curative factor is mastery over separation issues, while with Sifneos, Malan and Davanloo, the factor is insight into the central conflict.

**Outcome.** There have been no published research projects on T-LP to date. Dasberg and Shefler's ongoing research study in Jerusalem (cited in Mann, 1991) does report, "clear positive outcomes", particularly in the areas of "self-esteem, social functioning and target symptoms" (p. 42).

### *Strupp's Time-Limited Dynamic Psychotherapy*

Hans Strupp developed his technique of Time-Limited Dynamic Psychotherapy (T-LDP) at Vanderbilt. His technique is also highly based on the results of his many studies on what makes dynamic psychotherapy successful with patients. Binder and Strupp (1991) explain that the approach attempts a "greater integration of classical and interpersonal psychoanalytic theory and technique" (p. 138), with the more recent studies of countertransference reactions. It is a combination of psychoanalytic theory with a theory of personality based on object relations and interpersonal theories of development. The method examines internalized object relations as they are played out in the relationship with the therapist.

**Selection.** Patients who can benefit from this treatment include those whose internalized object relations are marked by: "1. coherent and identifiable interpersonal themes, (2) appreciation of the distinction between oneself and others, and (3)a capacity for concern and integrity in human relationships" (Binder & Strupp, 1991, p. 139). Patients who would be ruled out include those who are psychotic, whose object relationships are very disorganized, and those who have no desire to study their interpersonal relationships. This method does not rule out any other particular diagnostic categories.

**Technique.** The technique aims to:

(1) Create a safe environment in which the patient can replay dysfunctional relationships.
(2) Allow these patterns to emerge.
(3) Aid patients in observing what they are repeating in the present.,

(4) Help the patient examine what is behind these dysfunctional patterns.

The main way to begin to accomplish the above goals is to begin to look closely at the therapist-patient relationship. A specific number of sessions is not set, but a termination date might be set at the outset of treatment.

The overarching goal of T-LDP is to improve interpersonal functioning. In studying patient's interpersonal functioning, the concept of the "Cyclical Mala-daptive Pattern (CMP)" (Binder & Strupp, 1991, p. 140) is used. It has to do with patients' repetitive patterns of interpersonal relationships, and their intro-ject. In this, it is somewhat similar to Luborsky's concept of the core Conflictual Relationship Theme. These ideas are based on the work of Harry Stack Sullivan and other interpersonal theorists. The CMP has four components (Binder and Strupp, 1991): (1) "acts of self" (p. 140) towards others; (2) "expectations about others' reactions" (p. 140); (3) "acts of others toward self" (p. 140), or how do other people respond to the patient; and (4) "acts of self toward self" (p. 140), or the introject.

When the treatment begins, a central "maladaptive interpersonal pattern" (p. 140) is identified. Then, in each session, the therapist identifies a theme which is related to this focus. This theme is seen in the interplay of the therapist-patient relationship. The therapist may clarify and interpret conflicts which are seen in the patient's relationships outside therapy. Eventually, final interpretations involve relating similar patterns in relationships both inside and outside the treatment room. The therapist explores all aspects of a person's interpersonal relationships as they are related to the therapist, and looks for ways to relate these back to the therapeutic relationship. Unlike several of the other short-term therapists, the patient's receptiveness to potential interpretations is taken into account before offering an interpretation. The therapist's manner in T-LDP is somewhat distanced and analytical, and the main approach is one of exploration rather than education. This is very different from the educative styles of Davan-loo, Sifneos and Malan.

The CMP method first explores the here and now relationship in a careful fashion, and links are not made to past relationships until the patient can first see the current CMP which is in operation, and understand it. Secondly, the therapist looks for similar patterns in other relationships the patient currently is engaged in. Thirdly, the therapist and patient search for the origin of the interpersonal patterns. The feeling of the therapy at this point is more exploratory than aggressive or forceful. Finally, a full interpretation is made only after the patient makes a past-present relationship connection themselves (without help from the therapist).

**Outcome**. Two major studies on psychotherapy outcome are cited by Binder and Strupp (1991) and Strupp and Binder (1984), which concentrate on the factors that relate to good outcome in psychotherapy. The Vanderbilt I study examined a group of college students treated with T-LDP and found that outcome was related to the quality of the therapeutic relationship, that is, if the patient felt "accepted, understood, and liked by the therapist" (Binder and Strupp, 1991, p. 157), the outcome was more likely to be successful. The second study, or the Vanderbilt II study found that therapists trained to use the T-LDP technique

with a training manual may often not be as effective as more experienced therapists because they are simply rehearsing lines. The reader is referred to Strupp and Binder's 1984book for a more detailed description of these studies.

### *Klerman's Interpersonal Psychotherapy*

Klerman's Interpersonal Psychotherapy (IPT) (Kierman, Weisman, Rounsaville and Chevron, 1984) is another short-term method which is based more on nondirective exploration than on directive confrontation. Most symptoms are viewed as being due, in part, to problems in interpersonal relationships, and so the focus of the treatment is on the therapeutic relationship.

**Selection.** Kierman treats a wide variety of patients with this method, and has a special, modified technique for use with depressed patients (1984). The IPT model for depression is based on the idea that depression {and other forms of psychopathology) are intimately connected with problems with social relationships. The initial interview, then, will concentrate on investigating such potential difficulties in a person's life as: a recent loss of a relationship; problems in forming intimate relations with people; a decrease in social functioning either at home or work and; marital problems.

**Technique.** IPT sees as its two main goals the alleviation of symptoms, and the increasing of self-esteem. In the early sessions, the therapist assesses the patient's current social relationships. The focus of the treatment is in the present, and uses problem-solving, emotional support, emotional support, clarification of feelings, and help with improving communication as its main interventions. There is no interpretation of transference, and any discussion of earlier life events maintains a present focus, rather than highlighting past patterns. IPT therapists will try to clarify patients' feelings, give support, and enhance communication skills.

The technique is more educative than interpretive. The patient is helped to be able to recognize and accept all of his/her feelings. The therapist teaches more effective means of communication. Finally, the therapist-patient relationship may be focused on, but only as it relates to discussions of outside relationships, not in terms of transference issues. Many concrete techniques are used to solidify gains such as; modelling, role-playing, advice-giving, contract-setting, education, and help with making decisions.

Schacht and Strupp (1989) summarize the four steps involved in the first stat of therapy. These steps include: (a) giving a standard scale to measure degree of depression (if this is the presenting problem), (b) providing information to the patient about their condition, (c) assessing the need for medication, and (d) identifying the specific interpersonal difficulties.

The second stage of the process involves a systematic amelioration of the interpersonal problems. The therapist and patient first fully investigate the full scope and nature of the problem. Next, the patient is helped to have and accept all of his/her feelings. Thirdly, the patient's communication problems are studied, and more adaptive modes of communicating are taught. Next, the therapist helps the patient examine ways in which these maladaptive interpersonal styles

show themselves in the relationship with the therapist. Finally, more specific techniques are used to solidify the work done so far, such as modelling, advice giving, education and role playing.

**Outcome**. IPT is related to improved mood, decreased suicidal ideation, increased performance and interest, and decreased guilt (Schacht and Strupp, 1989). It has also been found to be very effective with relieving symptoms of depression (Elkin, Shea, Watkins, Imber, Satsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester and Parloff, 1989). In fact 4-8 weeks of IFT was just as successful in treating depression as medication. The Elkin *et al.* (1989) study compared IPT with antidepressant medication and cognitive behavior therapy, and found all three methods to be equally successful on the amelioration of depressive symptomology.

## Discussion

"The ultimate aim of all dynamic psychotherapy is that the patient should experience to the full the true feelings against which he has been defending himself because they are loaded with anxiety or pain" (Malan, 1986, p. 64). To a greater or lesser extent, and with a differing emphasis on certain feelings, all the major schools of short-term dynamic therapy have this in common. The first three methods discussed, those of Davanloo, Malan, and Sifneos, adhere very closely to this more classical psychoanalytic approach. The theme in these approaches is that in order for the therapy to be successful, the patients should become aware of their central conflict and the underlying feelings, and gain insight into the defenses they use to prevent awareness of their true feelings. The last four techniques reviewed, those of Luborsky, Mann, Strupp, and Ker-man, are more exploratory than educative or interpretive in focus, and incorporate some of the ideas of either object relations theory or interpersonal theory into their aims. This broadens the goal to improving interpersonal functioning with less distinct focus on making the unconscious conscious.

*Davanloo* makes more use of trial therapy in the initial evaluation process than any other short-term psychotherapist. Except for his recent technique or restructuring the defenses,and using more questions and challenges than interpretation, Davanloo's technique is very classical in style, with its focus on interpretation of transference and making the unconscious conscious. Resistances are pointed out in the first session and are constantly challenged. Patients are actively encouraged to give up their resistances, which is vaguely reminiscent of Freud's early technique of laying of hand on the patient's forehead to force them to say everything on their mind. Although the therapist remains neutral, because of the constant challenging, the therapy reaches a high emotional intensity, and is carried out at this level. The work moves very quickly, with numerous psychodynamic formulations being given. It is a most forceful technique. Although the work is emotional, the interventions are intellectual in nature. An advantage to davanloo's school is that the detailed published transcripts readily facilitate comparisons with other schools of thought, and allows others to scientifically evaluate the efficacy of each and every intervention.

*Sifneos's* technique is more similar to Davanloo's in being a more classical technique, and more forceful in the removal of resistance. However, Sifneos works much more in the positive transference, whereas Davanloo's technique very quickly moves into the negative transference, usually in the first session. Sifneos's interpretations directly address the underlying conflict, bypassing the resistance. This is a controversial technique, because of the amount of anxiety it can arouse, and none of the other methods reviewed here employ this intervention. Sifneos, in stark contrast to the other schools cited here, states that he does not work with the transference neurosis. He uses reinforcement, which sets him apart from Davanloo and Malan. his technique seems to work best with oedipal level problems, and with a predominance of positive feelings. However, he had also shown it to be effective with psychosomatic patients, and several other more resistant diagnostic groups.

*Malan's* original method has changed quite a bit, and now incorporates Davanloo's more recent work. Although Malan uses interpretation, and his is a highly intellectually based, educative approach, like that of Sifneos and Davanloo, his style is not as confronting as Davanloo's. He allows somewhat more dependency on the therapist, and considers the transference-parent linking interpretations a very important factor. In general, these first three approaches reviewed do not focus on the termination, or on the actual relationship between therapist and patient, but on the internal, intrapsychic factors, and on making these conscious.

*Luborsky's* SE Psychotherapy incorporates a number of classical elements, but also embraces a number of characteristics of interpersonal psychotherapy. Interpretations are shorter, and less complex, which is in stark contrast to the above three methods. Symptoms are framed as coping attempts, thus shielding the patient's ego. In addition, a wider range of patients are able to be reached because the supportive techniques are built into the theory. There is more processing of the meaning of termination and separation, and interpretations are much more geared to the patient's level of readiness. Luborsky is the only short-term psychotherapist to include a discussion of the usefulness of, and actual need for therapists studying their own countertransference feelings.

*Mann's* approach is primarily based in self-psychology, and object relations theory, and not on drive-defense, or classical technique. Rather, the concentration is on replicating in the treatment room, the early problems of dependence on the mother. The focus is on separation-individuation, preoedipal issues, self-esteem, and self-reliance. Unlike the other brief dynamic therapies, a very strict 12-session limit is adhered to. the therapy has a present-day focus, and the use of empathy is central. The techniques are much more gentle with the patient's defenses, which helps prevent further narcissistic injury. The style is more one of exploration, than education, and cure is seen as mastery over separation issues rather than insight.

*Sirupp's* method, like Luborsky's, is highly empirically based, making them both very fine models for psychotherapy research. This school consciously integrates classical, interpersonal, and object relations approaches. The goal is to improve interpersonal functioning, and to this end, the therapist examines the internalized object relations as they play themselves out with the therapist. Strupp also, like Luborsky and Mann, uses more exploration than education

as a primary tool, and the interventions are not forceful in character. A full interpretation is made only after the patient makes part of the connection themselves .

*Klerman's* method is strictly interpersonally based. The focus is on relationships with other people. There is a specific IPT for depression, making it more accessible to a broader group of patients. The therapy concentrates on the present, employing more supportive techniques, and on increasing self-esteem. It is more educative than interpretive or exploratory.

Although the seven months of brief dynamic therapy covered in this paper owe much to Freud for his contributions of the unconscious, resistance and transference, it is interesting to observe that the evolution of the field of short-term dynamic therapy in many ways recapitulates the developments in the field of longer-term dynamic psychotherapy. That is, although each of these methods began by strictly limiting the type of patients considered suitable for the technique, they all have included various modifications to enable their practitioners to treat wider range of patients. In general, this has included adding supportive techniques to strictly insight-oriented techniques. It will be interesting to continue to observe the evolution of this still-new field over time.

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